STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	11/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAND TERRACE OF CARMEL	689 PRO MED LANE, CARMEL, , 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00366867. Complaint IN00366867 - Substantiated. State deficiencies related to the allegations are cited at R296. Survey dates: November 18 and 19, 2021 Facility number: 013510 Residential Census: 81 This State Residential Findings is cited in accordance with 410 IAC 16.2-5. Quality review was completed on November 24, 2021.	R 0000		

R 0296	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(b) (b) The facility shall maintain clear written policies and procedures on medication assistance. The facility shall provide for ongoing training to ensure competence of medication staff. Based on interview and record review, the facility failed to ensure medications were administered as ordered by the resident's physician for 1 of 6 residents reviewed regarding medication administration. (Resident B) Findings include: The record for Resident B was reviewed on 11/18/2021 at 10:52 a.m. Diagnosis included, but were not limited to, Parkinson's disease, dystonia (involuntary muscle contractions which cause repetitive or twisting movement), hallucinations, ataxic gait (difficulty walking), mild cognitive impairment and anxiety disorder. Progress notes, dated 04/20/2021 at 5:50 a.m., indicated the resident "took pills whole". Admission notation, dated 04/20/2021 at 7:19 a.m., indicated Resident B was alert	R 0296	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: a. Only the resident identified is known to have been affected by the deficient practice. The resident no longer resides at the community. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: a. By 12/31/2021, the medication and other pertinent records of residents receiving medication management will be audited by the consultant pharmacist with clinician follow-up to report findings as warranted. b.	12/31/2021

and oriented. The resident was well groomed. The resident walked using a rollator (rolling walker). The resident's gait was unsteady but quick. The resident and daughter reported episodes of "freezing" related to Parkinson's disease.

1. An order from the Nurse Practitioner (NP), dated 07/08/2021, indicated the following:

Lisinopril (a medication for high blood pressure) 5 mg (milligram) one half a tablet (2.5 mg) by mouth every evening to start on July 08, 2021 and end on 08/06/2021. Discontinue Lisinopril 5 mg every evening and see the new order above.

The order for the Lisinopril was entered into the computer by the nurse, on 07/08/2021, and transcribed as:

Lisinopril Tablet 5 mg. Give 1.5 tablet by mouth one time a day for blood pressure. Three times the prescribed medication. The end date for this medication was transcribed as "Indefinite".

Instructions indicated to take the resident's blood pressure prior to administration and hold the medication if the resident's systolic blood pressure was below 110. A review of the blood pressure readings for the 45 day period the resident received the medication

By 12/31/2021, the health and wellness director (HWD) or licensed nurse designee will initiate random medication administration observations of QMAs once weekly for 30 days rotating to cover all shifts to determine compliance with EMAR medication administration instructions and policies and procedures involving crushing of medications. If any errors are observed, the medication incident policy will be followed. Observations will continue for 30 days until there is a full 30 days of no identified errors.

c. By 12/31/2021, licensed nurses will be trained on and initiate documentation of medication incidents in the electronic health record versus using a paper process.

d. By 12/31/2021, the HWD or licensed nurse designee will timely complete an electronic medication incident report for any identified errors, notify the executive director (ED), MD, and

	indicated on 19 of the 45 days the resident's blood pressure was below the stated parameters with some blood pressure readings reaching as low as 72/54, 89/55, 87/57 and 84/64. The resident's blood pressure was taken as many as 4 times a day due to the low blood pressure and the readings remained below the parameters 34 times. During an interview, on 11/19/2021 at 10:21 a.m., the interim Health Services Director (HSD) indicated the order had been transcribed by an assistant to the previous HSD and the resident had received the Lisinopril from 07/09/2021 through 08/23/2021. 2. A progress note, dated 10/29/2021 at 4:20 p.m., indicated a QMA (Qualified Medication Aide) crushed the resident's ER (extended release) Sinemet (a medication for Parkinson's disease) for the resident's noon dose. The ER Sinemet was not to be crushed per pharmacy orders. The family was aware of the mistake as well as the NP was also aware. The Physician's order for Sinemet Extended Release indicated to give 25-100 mg three times a day. The medication administration record indicated the same QMA had passed medications to		resident/POA, and follow the Medication Incident policy and procedures for disciplinary follow-up and provide retraining to the QMA as warranted. The QMA who committed the error will be included in the above referenced weekly medication administration observations. Any incidents involving improper crushing of medications, or where otherwise deemed warranted, will be submitted for review by the quality assurance and improvement program committee. 3. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not reoccur: a. By 12/31/2021, QMAs will be in-serviced on the requirement to follow the EMAR and medication packaging to include the prohibition on crushing meds unless directed in the EMAR. b.	

	Resident B on 10/03/2021, 10/10/2021, 10/22/2021, 10/25/2021 and 10/29/2021. During an interview, on 11/19/2021 at 12:42 p.m., Resident B's Nurse Practitioner (NP) indicated it was her professional opinion the resident's increasing behaviors were directly attributed to the crushing of the extended release medication. She indicated knowing the resident's daughter had witnessed this practice on 10/29/2021, she felt this was not an isolated event and likely to have been an ongoing concern. During this interview, the NP also expressed great concern regarding the medication transcription error related to Resident B's Lisinopril. During an interview, on 11/19/2021 at 2:13 p.m., the interim HSD indicated during her investigation of the incident, the Sinemet medication for this resident was clearly marked on the medication packet "Do Not Crush". The HSD believed the QMA crushed the medication due to the resident had been refusing her medications at previous times and she wanted to ensure the resident got her medications. She added she felt the QMA did not understand the importance of not crushing the medication. The QMA was no longer working at the facility		By 12/31/2021, medication incidents will be documented in the electronic health record versus using a paper process. The HWD and ED will review medication incidents per community policies and procedures and submit the incidents for review by the quality assurance and improvement program committee as warranted. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not reoccur, i.e., what quality assurance program will be put into place: a. By 12/31/2021, the HWD or licensed nurse designee will initiate random medication administration observations of QMAs once weekly for 30 days rotating to cover all shifts to determine compliance with EMAR medication administration instructions and policies and procedures involving crushing of medications. If any errors or improper practices are observed, the Medication Incident policy	

following the event on 10/29/2021.

The facility changed ownership, effective 11/09/2021, after the medication errors were made. A policy and procedure, regarding following physician orders and medication administration, was unavailable for review from the previous ownership at the time of the investigation.

This State Tag relates to Complaint IN00366867.

Based on interview and record review, the facility failed to ensure medications were administered as ordered by the resident's physician for 1 of 6 residents reviewed regarding medication administration. (Resident B)

Findings include:

The record for Resident B was reviewed on 11/18/2021 at 10:52 a.m. Diagnosis included, but were not limited to, Parkinson's disease, dystonia (involuntary muscle contractions which cause repetitive or twisting movement), hallucinations, ataxic gait (difficulty walking), mild cognitive impairment and anxiety disorder.

and procedures will be followed. Observations will continue for 30 days until
there is a full 30 days of no identified errors.

b.
By
12/31/2021, the HWD or licensed nurse designee will timely complete an
electronic medication incident report for any identified errors, notify the ED,
MD, and resident/POA, and follow the Medication Incident policy and procedures
for disciplinary follow-up and provide retraining to the QMA as warranted. The
QMA who committed the error will be included in the above referenced weekly
medication administration observations. Any incidents involving improper
crushing of medications, or where otherwise deemed warranted, will be submitted
for review by the quality assurance and improvement program committee.

c.
Consultant
pharmacists will continue to conduct medication regimen reviews. Consultant
pharmacist reports identifying errors will be submitted for

Progress notes, dated 04/20/2021 at 5:50 a.m., indicated the resident "took pills whole".

Admission notation, dated 04/20/2021 at 7:19 a.m., indicated Resident B was alert and oriented. The resident was well groomed. The resident walked using a rollator (rolling walker). The resident's gait was unsteady but quick. The resident and daughter reported episodes of "freezing" related to Parkinson's disease.

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Instructions indicated to take the

review to the community QAIP committee for review and follow-up as warranted.

	resident's blood pressure prior to administration and hold the medication if the resident's systolic blood pressure was below 110. A review of the blood pressure readings for the 45 day period the resident received the medication indicated on 19 of the 45 days the resident's blood pressure was below the stated parameters with some blood pressure readings reaching as low as 72/54, 89/55, 87/57 and 84/64. The resident's blood pressure was taken as many as 4 times a day due to the low blood pressure and the readings remained below the parameters 34 times. During an interview, on 11/19/2021 at 10:21 a.m., the interim Health Services Director (HSD) indicated the order had been transcribed by an assistant to the previous HSD and the resident had received the Lisinopril from 07/09/2021 through 08/23/2021.			

2. A progress note, dated 10/29/2021 at 4:20 p.m., indicated a QMA (Qualified Medication Aide) crushed the resident's ER (extended release) Sinemet (a medication for Parkinson's disease) for the resident's noon dose. The ER Sinemet was not to be crushed per pharmacy orders. The family was aware of the mistake as well as the NP was also aware.

The Physician's order for Sinemet Extended Release indicated to give 25-100 mg three times a day. The medication administration record indicated the same QMA had passed medications to Resident B on 10/03/2021, 10/10/2021, 10/22/2021, 10/25/2021 and 10/29/2021.

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE